



Department of Administrative Services

Authorization to Disclose Health Information

Client Name _____ Date of Birth _____
Client Claim # _____ Client SS # _____

I _____ hereby authorize the Connecticut Department
(Client or Personal Representative)
of Administrative Services to disclose specific health information from the records of the above named client to:

(Recipient Name/Address/Phone/Fax)

for the specific purpose(s):

Specific information to be disclosed:

I understand that this authorization will expire on the following date, event or condition:

I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation Section* on the back of this form. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits.

I further understand that I may request a copy of this signed authorization.

(Signature of Client)

(Date)

(Witness-If Required)

(Signature of Personal
Representative)

(Date)

(Personal Representative
Relationship/Authority)

NOTE: This Authorization was
revoked on

(Date)

(Signature of Staff)

The confidentiality of this record is required under chapter 899 of the Connecticut general statutes. This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statutes.



Department of Administrative Services

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of _____
(Name of Client)
signed by _____ on _____
(Enter Name of Person Who Signed Authorization) (Enter Date of Signature)
be rescinded, effective _____. I understand that any action taken on this authorization prior to the
(Date)
rescinded date is legal and binding.

(Signature of Client)

(Date)

(Signature of Witness)

(Date)

(Signature of Personal
Representative)

(Date)

(Personal Representative
Relationship/Authority)